REPORT OF NAME OR ADDRESS CHANGE

California Health and Safety Code section 30406 requires that any individual issued a X-ray Technician Limited Permit, Radiologic Technology Certificate, Supervisor and Operator Certificate or Permit to report any change in their name or address within 30 days to this Department.

Certificate/Permit Number _____

Daytime Telephone _____E-mail Address_____

Signature_____ Date_____

PREVIOUS NAME AND ADDRESS:

Name _____

Address _____

City, State, Zip Code _____

CURRENT NAME AND ADDRESS:

Name _____

Address _____

City, State, Zip Code _____

MAIL OR FAX TO:

California Department of Health Services
Radiologic Health Branch, MS 7610
P.O. Box Number 997414
Sacramento, CA 95899-7414

FAX (916) 440-7999
Telephone (916) 327–5106
Internet Address: www.dhs.ca.gov/rhb

For DHS/RHB Use Only:

Verified By _____ Date_____
Entered By _____ Date_____